DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

REVISED

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: MA 03-017

2. STATE: South Carolina

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
01/01/04

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY N/A $
b. FFY N/A $

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Index Page Number 71 - Delete
Attachment 3.1-A, Limitation Supplement, Pages 8z.1, 8z.2, 8z.3 & 8z.4; Supplement 1 Attachment 3.1-A, Page 1(m) & Attachment 4.19-B, Pages 6e, 6f & 6g

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Index Page Number 71-Delete
Attachment 3.1-A, Limitation Supplement Page 8z.1 and Attachment 4.19-B, Pages 6e & 6f

10. SUBJECT OF AMENDMENT:
Managed care contracts.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Mr. Kerr is the Governor's Designee to sign State Plan Amendments

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Robert M. Kerr

13. TYPED NAME: Robert M. Kerr

14. TITLE: Director

15. DATE SUBMITTED:
December 18, 2003

16. RETURN TO:

South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
December 22, 2003

18. DATE APPROVED:
[illegible]

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2004

20. SIGNATURE OF REGIONAL OFFICIAL:
Renard L. Murray

21. TYPED NAME:
Renard L. Murray, D.M.

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS:

associated with allowable case management service delivery. The rate will be prospectively determined by using an average monthly caseload and the average cost of the case manager including support costs. Payment to public providers will not exceed the actual allowable cost of rendering the service. The requirements of 42 CFR 447.321 or 42 CFR 447.325 will not be exceeded.

Case management services provided by private providers will be reimbursed on a fee-for-service methodology based on the delivery of units of service. The unit of service will be a month. Payment to private providers will not exceed the established statewide average cost for the service.

19.n Primary Care Case Management (PCCM) providers will receive a case management fee on a per enrolled member per month basis. The amount of the fee will be based on the scope of services covered by the case management/care coordination entity. The total amount may be shared between the primary care physician and Medical Homes Local Network Board. The combined amount will be no more than $5.00 per member per month. Incentive payments may be made to providers if both quality of care standards are met or exceeded and cost savings are achieved. The determination of cost savings will be based on an analysis of total per member per month cost to the Medicaid program.

1. Incentive payments to the PCCM may not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered;
2. The incentives must be based upon specific activities and targets;
3. Incentives must be based upon a fixed period of time;
4. Incentives may not be renewed automatically;
5. Incentives must be made available to both public and private PCCMs; and
6. Incentives must not be conditioned on intergovernmental transfer agreements.

20.A & B Extended pregnancy related services are reimbursed individually at an established fee-for-service rate. All service rates are based on a statewide average cost for the service. Services rendered by public agencies will not exceed cost as required in 42 CFR 447.321 or 42 CFR 447.325.

24. Transportation: (Effective 3-10-87)

Ambulance: Payment for ambulance services will be the lesser of actual charges submitted by the carrier or the ceiling of the fees established by DHHS. The fee schedule will be applied uniformly without consideration of locality. In the aggregate, fees do not exceed Medicare (Title XVIII) reimbursement for the same service.

Other type of transportation: Reimbursement for other types of transportation not available free of charge is made on the following basis.

- Transportation provided by a common carrier at actual cost.
- Negotiated agreement on a cost per mile basis with organizations providing such services.
- Transportation by volunteers at a traveled fixed rate per mile.
- Transportation by taxi with a negotiated agreement on a fixed rate per mile.

24.g Birthing Center: Payment will be made at an all inclusive facility rate according to an established fee schedule.

Program of all-Inclusive Care for the Elderly (PACE):

A. PACE Upper Limit Calculation:

1. Paid claims data from the SC Medicaid Management Information System (MMIS) is pulled for all Medicaid covered services which will be covered by the PACE program using the following criteria:

- All covered Medicaid service costs (including Buy-in premiums) incurred by eligibles residing in nursing facilities located in Richland and Lexington counties are accumulated. State owned/operated nursing facilities and intermediate care facilities for the mentally retarded (i.e., ICF/MRs) are excluded from this analysis. Richland and Lexington counties represent the PACE site service area.

- All covered Medicaid service costs (including Buy-in premiums) incurred by eligibles participating in the Community Long Term Care (CLTC) Program that reside in Richland and Lexington counties are accumulated. Additionally, case management costs originating from the CLTC area office which are reimbursed outside of South Carolina's MMIS are also included as a service cost. Richland and Lexington counties represent the PACE site service area.

- The dates of service used in this analysis will cover the period December 1, 2001 through September 30, 2002 due to the state plan approval process employed by CMS.

- Eligibility categories used in this analysis include both Medicaid and dual eligible recipients.

2. In addition to the determination of service cost from the paid claims data, member months will also be determined from the claims data. Member months for nursing facility eligibles are defined as whole or partial member months depending upon the admission and/or discharge date of the nursing facility resident. For eligibles participating in the CLTC program, member months are defined as whole or partial member months depending upon the entry and/or departure from the CLTC program.

3. Medicaid service costs incurred by eligibles residing in nursing facilities and participating in the CLTC program will be adjusted by service specific inflation trends resulting from the implementation of Medicaid policy changes that were implemented during or after the claim reporting period but prior to the effective date of the rate period. Additionally, the South Carolina Department of Health and Human Services (SCDHHS) reserves the right to adjust the initial PACE Medicaid rate in the event of Medicaid policy changes during the course of the PACE rate period, subject to prior approval by the CMS regional office.

4. Medicaid service cost expenditures as determined in (3) above will be accumulated separately for eligibles residing in nursing facilities and eligibles participating in the CLTC program. Additionally, member months as determined in (2) above will be accumulated separately for eligibles residing in nursing facilities and eligibles participating in the CLTC program. Total Medicaid service costs for each group (i.e., nursing home residents and CLTC participants) will be divided by total member months for each group to determine an average nursing home member month cost and an average CLTC member month cost.

5. In order to calculate the upper payment limit for PACE participants, an adjustment for patient acuity must be made. Therefore, the average nursing home member month cost and the average CLTC member month cost as determined in (4) above will be weighted to determine the upper payment limit for PACE participants.

B. PACE Medicaid Rate Calculation:

The Medicaid rate for PACE participants will represent 90% of the weighted UPL as determined in (5) above.

Required credentials for a Case Manager Assistant will include no less than a high school diploma or GED, and skills/competencies sufficient to perform assigned tasks or the capacity to acquire those skills/competencies.

F. Free Choice of Providers

All adults eligible for Medicaid and the subject of an abuse or neglect report referred to the South Carolina Department of Social Services will be eligible to receive these case management services. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of case managers and the freedom to switch case managers if and when they desire.

2. Eligible recipients will have free choice of providers of other medical care under the state plan. Case managers will assure that freedom of choice of physicians and other medical care providers is maintained at all times.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Services for clients who are insured by a third party payor which covers the cost of case management will be reimbursed by the third party payor. Title XIX funds will be used when a client has no third party coverage and is eligible for Medicaid. The few remaining clients will have their case management services funded by Social Services Block Grant or state funds.

19. CASE MANAGEMENT - Primary Care Case Managers

Under the authority of section 1905(t) of the Social Security Act, the state will enroll Medicaid clients with Primary Care Case Managers (PCCMs) on a voluntary basis.

I. GENERAL DESCRIPTION OF THE PROGRAM

The State contracts with PCCMs. PCCM contracts are non-risk based and services are paid on a fee-for-service basis. The PCCMs are paid a monthly Per Member Per Month (PMPM) Case Management fee. The PCCMs are members of the Medical Homes program.

II. ASSURANCES AND COMPLIANCE WITH THE STATUTE AND REGULATIONS

The State plan program meets all the applicable requirements of

- Section 1905(t) of the Act for PCCMs and PCCM contracts.
- 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in Section 1905 (a)(4)(C)

- 42 CFR Part 438 for PCCMs

III. ELIGIBLE GROUPS

All Medicaid eligible clients may enroll in the PCCM program, except the following:

- Those enrolled in SILVERxCARD, the South Carolina Seniors' Prescription Drug Program Act (S.C. Code Ann. § 44-130-10);
- Those enrolled in the Family Planning Waiver;
- Those enrolled in another managed care entity;
- Those enrolled in the Medically Fragile Children's Program;
- Those enrolled in any Home and Community Based Waiver;
- Those enrolled in Hospice;
- Those enrolled who are institutionalized; or
- Those with limited Medicaid Benefits.

IV. ENROLLMENT PROCESS

A. MANAGED CARE ENROLLMENT

1. Once eligibility has been established, all beneficiaries are sent a packet welcoming them to Medicaid, informing them of their health care choices and inviting them to call the Beneficiary Services toll free line to obtain more information about the choices in their geographic area.

2. If a beneficiary chooses a PCCM, enrollment begins the first day of the following month. If the beneficiary chooses a PCCM after the 10th day of the month, the enrollment begins the first day of the second month following the date of the beneficiary's choice.

3. Enrollment is for a twelve (12) month period. At the beginning of each enrollment period the member will have ninety (90) days to exercise their option to disenroll from their plan.

B. STATE ASSURANCES ON THE ENROLLMENT PROCESS

1. The State has an enrollment system that allows beneficiaries who are already enrolled to be given priority to continue that enrollment if the PCCM does not have capacity to accept all who are seeking enrollment under the program.

   The State does not require clients to enroll in a PCCM. Therefore, the choice requirements in 42 CFR 438.52 are met.

2. NA The State Plan program applies the rural exception to choice requirements of 42 CFR 438.52 (a) for MCOs and PCCMs. (Please check mark to indicate state's affirmation.)

C. DISENROLLMENT

1. What are the additional circumstances of ''cause'' for disenrollment? (If any.)

   a. The beneficiary moves out of the provider's service area.
   b. The provider moves out of the service area available to the beneficiary.
   c. The provider does not, because of moral or religious objections, provide the service the beneficiary needs.
   d. The beneficiary needs related services (for example, a cesarean section and a tubal ligation) to be performed at the same time, not all related services are available by the provider, and the beneficiary's primary care provider or another provider determines that receiving the services separately would subject the beneficiary to unnecessary risk.
   e. Administrative error on the part of the Department or its designee, or the PCCM including, but not limited to, system error.
   f. Poor quality of care, as documented by the Department.
   g. Lack of access to covered services, as documented by the Department.
   h. Lack of access to providers experienced in dealing with the client's health care needs, as documented by the Department.
   i. The beneficiary's PCCM leaves the program.

2. Members may opt out of the PCCM program for any reason, anytime within the first ninety days of enrollment. Beneficiaries who do not opt out during the first ninety days must remain in the program for twelve (12) months. Disenrollment for cause may occur at any time.

3. Members may be disenrolled from the PCCM at the request of the PCP for good cause. Good cause includes, but is not limited to:

   - Behavior on the part of the member which is disruptive, unruly, abrasive or uncooperative to the extent that the ability of the provider to provide services to the member or other affected members is seriously impaired;
   - The member persistently refuses to follow a reasonable prescribed course of treatment; or
   - Fraudulent use of the Medicaid card.

V. INFORMATION REQUIREMENTS FOR CLIENTS

The State assures that its plan is in compliance with 42 CFR 438.10 for information requirements specific to PCCM programs operated under section 1932 (a)(1)(A) state plan amendments.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

PRIMARY CARE CASE MANAGEMENT SERVICES

A. Target Group: Medicaid eligible adults and children excluding:

1. Those enrolled in the Family Planning Waiver program;
2. Those enrolled in SILVERxCARD, the South Carolina Seniors' Prescription Drug Program Act (S.C. Code Ann. § 44-130-10);
3. Those enrolled in another managed care entity;
4. Those enrolled in the Medically Fragile Children's Program;
5. Those enrolled in any Home and Community Based Waiver;
6. Those enrolled in Hospice;
7. Those enrolled who are institutionalized; or
8. Those with limited Medicaid Benefits.

B. Areas of State in which services will be provided.

☒ Entire State

☐ Only in the following geographic area (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide.

C. Comparability of Services

☒ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

☐ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked o provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

N/A

E. Qualification of Providers:

N/A